IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 70030500000319669982

August 21, 2008

Brian Sawyer, Administrator
Aspen Park Healthcare
420 Rowe Street
Moscow, ID 83843

Provider #: 135093

Dear Mr. Sawyer:

On **August 13, 2008**, a Facility Fire Safety and Construction survey was conducted at Aspen Park Healthcare by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 3, 2008**. Failure to submit an acceptable PoC by **September 3, 2008**, may result in the imposition of civil monetary penalties by **September 23, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 17, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 17, 2008**. A change in the seriousness of the deficiencies on **September 17, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 17, 2008** includes the following:

Denial of payment for new admissions effective **November 13, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 13, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 13, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **September 3, 2008**. If your request for informal dispute resolution is received after **September 3, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Mark P. Grimes
Supervisor
Facility Fire Safety and Construction

MPG/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135093	A. BUILDING 01 B. WING _____	08/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK HEALTHCARE	420 ROWE ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V (111) construction with two partial basements. The building is fully sprinklered with smoke detectors in corridors and open spaces. It was built in 1965 and is currently licensed for 94 NF beds. The following deficiencies were cited at the facility during the annual Fire/Life Safety survey conducted on August 18, 2008. The facility was surveyed under the Life Safety Code, 2000 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70. The surveyor conducting the survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000	RECEIVED SEP 03 2008 FACILITY STANDARDS	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm	K 051	1. The pull station was replaced. 2. The entire alarm system was reviewed and a bid accepted for a new system. 3. New system is under installation now and will be completed soon. 4. Maintenance Director and ED or his delegate will monitor system and prn. 5. Through PI/QA these reviews will monitored monthly by the Maintenance Director and ED or his delegate. 6. August 29, 2008	8/29/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian V. Seavy	Executive Director	9/2/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 051	Continued From page 1 system to an approved central station. 19.3.4, 9.6 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had failed to ensure that the fire alarm could be initiated manually from one of three pull installations sampled. The census was 60 with potential to affect all occupants of the building. The findings include: Observation on August 13, 2008 at 10:50 a.m., disclosed that a pull station box in the south dining/activities room was not armed to provide immediate warning of a fire. The pull station could not be activated through a normal procedure as the box had been pulled away from the toggle switch that would need to be flipped for initiation of the device. The cover plate of the box was actually loose from the wall while suspended by the swivel hinges. Lack of ability to activate the fire alarm from the dining room would slow response time for protection of residents in case of fire.	K 051		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		

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K 072	Continued From page 2 No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and staff interview, it was determined that the facility had not ensured that all exits were maintained free from obstruction for one of five exit discharges sampled. The census was 60 and this condition had the potential to affect the entire resident population. The findings include: Observation on August 13, 2008 at 11:05 a.m. disclosed that two reach-in freezer units had been placed outside the exit door that was adjacent to the 300 wing and the kitchen corridor. The exit discharge was partially blocked by the freezers placed in the area while awaiting permanent placement; subsequently the discharge area was not maintained in a "free and unobstructed way". Staff stated during interview on August 13, 2008 at 11:10 a.m. that the new freezers were going to be installed in other areas as soon as there was a decision made for placement elsewhere. In the meantime the storage on the exit discharge was temporary until more storage area was found. Partial blocking of the exit discharge would affect full use by residents and staff who would be leaving the building in case of fire.	K 072	1. The freezers were removed from egress. 2. All facility exits were reviewed for proper egress. 3. Maintenance rounds will be done to monitor facility exits. 4. Maintenance Director and ED or his delegate will monitor rounds weekly and prn. Results will be reviewed in monthly PI/QA. 5. September 2, 2008	9/2/08

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story Type V (111) construction with two partial basements. The building is fully sprinklered with smoke detectors in corridors and open spaces. It was built in 1965 and is currently licensed for 94 NF beds. The following deficiencies were cited at the facility during the annual Fire/Life Safety survey conducted on August 18, 2008. The facility was surveyed under the Life Safety Code, 2000 Edition, Existing Health Care Occupancy in accordance with IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. Refer to federal deficiencies cited on CMS 2567 under K tags K051 and K072. The surveyor conducting the survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	C 000	RECEIVED SEP 03 2008 FACILITY STANDARDS	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.	C 226	Please see K tag POCs	9/2/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brian V. Saenz | Executive Director | 9/2/08

Bureau of Facility Standards

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C 226	Continued From Page 1 This Rule is not met as evidenced by: Refer to CMS 2567 and federal deficiencies.	C 226		